

## Health Care Access and Reimbursement Task Force

1-3:30 PM Maryland Dept. of Transportation

Monday, September 8, 2008

Task Force Members Present: Secretary John Colmers (Chair), Senator Rob Garagiola, Dr. George Bone, Ellen L. Kuhn for JB Howard, Ralph Tyler, Dr. Joseph Fastow, David Wolf, Stuart Guterman, Delegate Robert Costa, Megan Lower for Fannie Gaston-Johansson, Senator Thomas Middleton, Delegate Joseline Pena-Melnyk

Absent: Dr. Ivan Walks, T. Eloise Foster

Staff present: Rex Cowdry, Ben Steffen, Lydia Isaac, Linda Bartnyska

1. Minutes approved.
2. Overview of meeting, Ben Steffen, MHCC and Secretary John Colmers.
3. Report on the Findings of Two Studies Required Under SB 744. Kathy Paez, PhD, RN, Senior Research Scientist, Center for Health Research and Policy, Social and Scientific Systems.

Senate Bill 744 expanded this Task Force's charge by requiring recommendations on two issues—1. Whether primary care physicians should be allowed to receive reimbursement for providing mental health services; and 2. Whether carriers should provide incentives to practices for offering after hours care.

- a. Issue #1-Mental Health care reimbursement for PCPs. PCPs play an important role in screening for mental health disorders and in treatment, and the concern is that they are not reimbursed or are reimbursed at a lower rate for mental health care. Mental health disorders are highly prevalent in both adults and children, with 75% of antidepressants being prescribed by PCPs and twice as many people being treated by PCPs rather than psychiatrists for mental health disorders. The management of mental health issues by PCPs is supported by the IOM, AAFP, and the AAP, and some patients prefer it due to the perceived stigma of receiving psychiatric care. Psychiatrists play an important role however, as do non-MD providers. PCP management of mental health care does present issues of payment system disconnect (no payment or insufficient or reduced payments), especially since dealing with mental health issues is time intensive. Physicians bill according to overall composition of their payer arrangements. One way PCPs have dealt with this issue is to develop strategies to reduce the risk of claims denial. This includes submitting claims with the symptom coded (such as insomnia) rather than a mental health code, or placing a mental health diagnosis in secondary coding position, and avoiding the use of extended service E/M codes. These practices may have no effect on cost since

they are already common practice, or they may lead to increased costs due to PCPs billing using higher level E/M codes, increased screening, detection and treatment, and increased cost to a medical benefit payer if there are less referrals to psychiatry. Increasing a PCP's ability to manage mental health issues may improve access for more easily managed mental health disorders but will have little impact for those with more severe disorders. Recommendations for consideration include requiring payment of a reasonable number of PCP visits per year for mental health diagnosis under the medical benefit; requiring coordination of mental and medical health benefit so there are no gaps in payment of care; and convening a Med-America 'Style' Task Force of payers and providers to study and correct claims problems.

Task Force members discussed reasons why mental health is treated differently than other medical conditions. It was noted that quality is missing from this discussion, and that quality is not up to par. Good models that exist include the team approach to case managing care. It was also noted that often time PCPs, when they do get reimbursed, are getting paid more for providing mental health services than their colleagues in the mental health field, which is obviously problematic. It was also noted that mental health carve outs were not created due to medical science, and therefore provide an example of what happens when care is shifted to lower level providers and there is an increase in demand for services—diagnosis tends to get lost in treatment and quality is subpar.

- b. Issue #2—PCP reimbursement for after hours care. Definition of after hours care varies, but trends include servicing health problems which “cannot be deferred” until the next day, though the interpretation of that depends on perspective. Additional mitigating factors are the shortage of PCPs, rise in ED use rates by patients with a “usual source of care,” and hourly workers who cannot leave work during the day. Another key issue is how (and if) to compensate for telephone and electronic communications, which are an important component of after hours care. Currently in Maryland, the three levels of after hours care are Retail Clinics, Urgent Care Centers, and Hospital Emergency Departments, the first two of which are clustered mainly in the central and capital areas. Currently, providers generally do not compensate for telephone or eVisits, and do not pay more for after hours care. Many definitions of the medical home construct include after hours care as an integral component. Within the last year, some CPT codes have been added to reimburse for telephone and e-consults. Studies show a substantial potential for substitution, including 35% of Maryland ED visits in 2005 that could have been treated in primary care, and a case study from Colorado showing that after hours care offered by PCPs lead to a 50% lower rate of ED visits.

Task Force members noted that those physicians that do not give after hours care do not do so because reimbursement has been so low it has not been worth it, as well as

fear that if patients know they can call their doctor anytime they will flood their doctor with phone calls which, until this year, doctors have not had a code that they could bill this for. Other doctors have been doing after hours and telephone care for a long time, they just have not been reimbursed for it. Further, eVisits represent some HIPAA issues, and a practice pattern change would need to be undertaken.

Telephone care would present challenges to carriers to determine if phone calls occurred within 7 days of a visit. It was also noted that after hours care needs to be considered time and half, not just unit for unit. From a Medicare perspective, the question is how many patients will come out of the wood work when you start paying for these services. One of the things that make a medical home model attractive is that you have a lump sum payment to pay for some of these services. It can also be included as a quality measure for care that can be rewarded if you are evaluating for quality.

#### 4. Presentation of Possible Task Force Recommendations

Overview of the handout “Required areas for recommendations,” which identifies elements in the legislation needing response and outlines suggestions for Task Force members in an effort to begin to formulate recommendations. Task Force members were asked to keep in mind the significant restrictions on what the State is able to do, as well as considering fiscal constraints. There are only two meetings left after this one before the report to the General Assembly is due.

Task Force members reviewed the attached list of suggestions and identified the following issues.

- Shortage of primary care doctors. Another task force is currently looking at specialty shortages in rural areas, and reimbursement is closely tied to this. The question was posed to the insurance community as to what plans they have to address this? CareFirst responded that they are concerned and are looking at the issues, recognizing that reimbursement is just one piece of the issue. Loan forgiveness is also a key issue, and they would support a number of the recommendations listed here. They also believe there needs to be a realignment of incentives—i.e., a quality care program, and there is also an effort to modify patient demands and expectations. The question was raised as to the variability between states on reimbursement rates, and other states initiatives. Rates are based on CPT codes and are calculated using Medicare and Medicaid rates, as well as on what other carriers are paying. Consultants have been hired to compare CareFirst rates with other carriers. There is some evidence that the unit rate is lower in Maryland than nationally, but it is not clear if there is also greater volume in Maryland.

- Lack of competition in the insurance market—revisit rules to see if they can be amended to increase competition. MIA has been looking at this.
- Physicians' office as a small business— encourage the growth of small physician office practices; model as a successful small business, perhaps in the form of low cost loans, technology transfers, which could be done for low cost and not affect the State budget significantly.
- Change the wording of the law affecting the non-participating providers that are currently pegged to non-participating fees of Medicare. The recommendation on page 2 (3.1.i) addresses this.
- Bring all the payers together in one room in a way that minimizes anti-trust problems to craft a solution, one of which might be to modify the Medicare waiver or rate setting system in some way to allow for funds to be transferred to a physician reimbursement system. The danger in this is jeopardizing the CMS waiver. Medicare is grossly underpaying for some things and their formula is flawed— CareFirst says solution is some reorientation; developing some pilots.
- Hospital based physicians—Reimbursement rates for non-participating providers are at, or even below, those of participating providers for inpatient and outpatient E&M codes. This trend needs to be reversed if doctors are to be kept in Maryland. Need to work with hospitals on this issue. According to CareFirst data, 17% of their patients are 83% of their costs—the majority of this is probably hospital based charges. How these costs are managed in the hospital needs to be addressed, but the insurers have no reason/incentive to come to the table to discuss these. Non-participating fees for hospitals pegged on the lowest charge or to a “similarly licensed provider,” and needs to be pegged at least to the median charge; this is a formula that needs to be changed. Need to make some recommendations on balance billing provisions—staff has laid out some, and task force members are asked to supply additional suggestions.
- A loan forgiveness program tied to underserved areas and underserved specialties must be the cornerstone of our recommendations. Streamlining the credentialing process to reduce significant redundancy could be one source of funding for this—it is estimated that this could fund at least \$2-3 million a year in loan forgiveness (40-60 physicians per year statewide). This may be the low-hanging fruit that Sec. Colmers suggested the Task Force look for.
- Electronic health records would like to be discussed in Oct. as well.

Adjournment 3:25.

Respectfully submitted,

Laurel Havas